## Pittsboro Family Dentistry Eaglesoft Medical History

Patient Name: Birth Date: Date Created: Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions. Are you under a physician's care now? ○Yes ○No If yes Have you ever been hospitalized or had a major operation? ○ Yes ○ No If yes Have you ever had a serious head or neck injury? ○Yes ○No If yes Are you taking any medications, pills, or drugs? ○Yes ○No If yes Do you take, or have you taken, Phen-Fen or Redux? ○ Yes ○ No If ves Have you ever taken Fosamax, Boniva, Actonel or any other ○ Yes ○ No If yes medications containing bisphosphonates? Are you on a special diet? ○ Yes ○ No Do you use tobacco? ○Yes ○No Do you use controlled substances? ○Yes ○No If yes Women: Are vou... Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives? Are you allergic to any of the following? Aspirin Penicillin Codeine Acrylic Metal Latex Sulfa Drugs Local Anesthetics Other? If yes Do you have, or have you had, any of the following? Cortisone Medicine ○Yes ○No Hemophilia ○Yes ○No Radiation Treatments ATDS/HTV Positive ○Yes ○No ○Yes ○No Alzheimer's Disease ○ Yes ○ No Diabetes ○Yes ○No Hepatitis A ○Yes ○No Recent Weight Loss ○Yes ○No Anaphylaxis ○Yes ○No Drug Addiction ○Yes ○No Hepatitis B or C ○Yes ○No Renal Dialysis ○Yes ○No ○ Yes ○ No Easily Winded ○Yes ○No Hernes Rheumatic Fever ○Yes ○No Anemia ○ Yes ○ No Angina ○Yes ○No Emphysema ○Yes ○No High Blood Pressure ○Yes ○No Rheumatism ○Yes ○No Arthritis/Gout ○Yes ○No Epilepsy or Seizures ○Yes ○No High Cholesterol ○Yes ○No Scarlet Fever ○Yes ○No ○Yes ○No ○Yes ○No Artificial Heart Valve ○ Yes ○ No Excessive Bleeding Hives or Rash Shinales ○ Yes ○ No Artificial Joint ○ Yes ○ No Excessive Thirst ○ Yes ○ No Hypoglycemia ○ Yes ○ No Sickle Cell Disease ○ Yes ○ No Asthma ○ Yes ○ No Fainting Spells/Dizziness ○ Yes ○ No Irregular Heartbeat ○Yes ○No Sinus Trouble ○Yes ○No Kidney Problems Blood Disease Frequent Cough ○Yes ○No ○Yes ○No Spina Bifida ○Yes ○No ○ Yes ○ No Blood Transfusion ○Yes ○No Frequent Diarrhea ○Yes ○No Leukemia ○Yes ○No Stomach/Intestinal Disease ○Yes ○No Breathing Problems ○Yes ○No Frequent Headaches ○Yes ○No Liver Disease ○Yes ○No Stroke ○Yes ○No Genital Hernes ○Yes ○No Low Blood Pressure Swelling of Limbs Bruise Easily ○Yes ○No ○Yes ○No ○Yes ○No ○Yes ○No Glaucoma ○Yes ○No Lung Disease ○Yes ○No Thyroid Disease ○Yes ○No Chemotherapy ○Yes ○No Hay Fever ○Yes ○No Mitral Valve Prolapse Tonsillitis ○Yes ○No ○Yes ○No Chest Pains Heart Attack/Failure ○Yes ○No Osteoporosis **Tuberculosis** ○ Yes ○ No ○ Yes ○ No ○ Yes ○ No Cold Sores/Fever Blisters Heart Murmur ○Yes ○No Pain in Jaw Joints ○ Yes ○ No Tumors or Growths ○Yes ○No ○ Yes ○ No Congenital Heart Disorder ○Yes ○No Heart Pacemaker ○Yes ○No Parathyroid Disease ○Yes ○No Ulcers ○Yes ○No ○Yes ○No Convulsions ○ Yes ○ No Heart Trouble/Disease ○ Yes ○ No Psychiatric Care ○Yes ○No Venereal Disease Yellow Jaundice ○Yes ○No Have you ever had any serious illness not listed above? ○ Yes ○ No If yes Comments: To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status. Signature of Patient, Parent or Guardian:

Date: